From: Walkama, Susan [swalkama@Wheelerclinic.org]
Sent: Tuesday, November 19, 2013 4:07 PM
To: Schaefer, Mark C.
Subject: SIM

Mark:
It was a pleasure to meet with you yesterday. These are some systematic barriers and solutions to SIM implementation BH/primary care.

1.) DPH licensing does not allow for satellite licensing by a community BH provider in a physician practice. This is a significant barrier to co-location of adult services and adolescent SA treatment. All co-locations would need to be separately licensed under DPH. The Psychiatric Clinic for Children license under DCF allows for this type of co-location under a satellite license. DPH should modify reg to allow for satellite add on to license. If that occurs, satellites could be incorporated into that reg. Given the pace at which reg modification moves, this would be accomplished more quickly through legislative action.

2.) Primary care doctors do not get licensed by DPH as facilities. They are not accustomed to meeting the types of regulations that are required for facilities etc. under the license. You can get medical care in a primary care location that is unregulated compared to a BH OP facility. DPH and DCF satellite facility review should focus only on life safety issues and fire code. Primary care docs will not invest in facility modifications to be in compliance with our higher standard for facility regulation. Replacing stained ceiling tiles, stained chairs, carpet fraying etc.

3.) Commercial billing: Some commercial carriers (their MBHCO) will accept Wheeler's own credentialing, PSO and accreditation process in lieu of individual paneling of their staff. They delegate the credentialing of staff to us. This allows us to handle staffing changes in a more seamless manner and enables our providers to accept most commercial plans. Some companies still restrict the size of their networks and limit the number of clinicians that can be in the panel at any point in time. This would create billing problems in co-location projects and continuity of care in transitions. Commercial carriers would need to add new physician locations to a BH providers contract without argument as well.

4.) Commercial and Medicaid fee schedules: Standard OP fee schedules for commercial or Medicaid don't cover the integrated care activities of a behavioral health provider in a primary care office such as engagement (warm hand offs and initial pre-session engagement), case management, multi-disciplinary teaming and time for physician consultation. Codes for these services should be added to standard OP commercial fee schedules and Medicaid.

5.) State agencies and the BHP need to support community BH providers in their transition to open access. Insisting that providers maintain both first time appointment scheduling through an access center or other method and establish open access is redundant and creates additional expense. A provider could offer an initial appointment if the consumer requires it for some reason or there is a strong preference for an appointment but state agencies or BHP requiring either is offered undermines the open access concept and process. Providers must have reasonable wait times, mechanisms for review and monitoring and procedures and resources to staff up for unanticipated demand.

6.) Technical support: Training on co-location, communications and teaming from a multi-disciplinary perspective.

7.) Support EHR/technical development of standardized screening forms

8.) Technical supports for data extraction of BH and primary care data to assess quality outcomes and cost savings. Costs might increase initially to implement so being able to track savings overtime is important. Might there be any shared savings pilots with BH co-located providers, commercial carriers and larger practices that make a commitment to address co-location on a larger scale.
Susan

Susan Walkama, LCSW
President and CEO
Wheeler Clinic, Inc.
91 Northwest Drive
Plainville, CT 06062
Office: (860) 793-3568
Fax: (860) 793-3546
[redacted]

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